Making G8 leaders deliver: an analysis of compliance and health commitments, 1996–2006

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Abstract International health policy-makers now have a variety of institutional instruments with which to pursue their global and national health goals. These instruments range from the established formal multilateral organizations of the United Nations to the newer restricted-membership institutions of the Group of Eight (G8). To decide where best to deploy scarce resources, we must systematically examine the G8's contributions to global health governance. This assessment explores the contributions made by multilateral institutions such as the World Health Organization, and whether Member States comply with their commitments. We assessed whether G8 health governance assists its member governments in managing domestic politics and policy, in defining dominant normative directions, in developing and complying with collective commitments and in developing new G8-centred institutions. We found that the G8's performance improved substantially during the past decade. The G8 Member States function equally well, and each is able to combat diseases. Compliance varied among G8 Member States with respect to their health commitments, and there is scope for improvement. G8 leaders should better define their health commitments and set a one-year deadline for their delivery. In addition, Member States must seek WHO's support and set up an institution for G8 health ministers.

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Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. **الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.**

Introduction

How can international institutions encourage their member governments to commit to and comply with actions to improve global public health? This question is important for health policy-makers, who now have a diverse array of institutional instruments to choose from when allotting scarce resources to achieve their goals. At the international level, governments still use long-established, functionally focused, ministerial-guided multilateral organizations such as the World Health Organization and other organizations of the United Nations system.[1] However, governments increasingly have access to newer, informal, summit-delivered plurilateral institutions, most notably those of the Group of Eight (G8).[2]

Since 1996 the G8 has given particular attention to health issues, for example at its annual summit in St Petersburg in 2006.[3] Health policy-makers need to know which international institutions to rely upon. In addition, these organizations need to work together more effectively, as mutual reinforcers rather than rivals, in order to meet global health needs. For the purposes of this paper, health encompasses all references to public health, human health and well-being, ageing, infectious disease, health-related international organizations and initiatives, drug use, drug conventions, pharmaceuticals, medications, potable water, biotechnology and the impact of bio-terrorism on human health.

To assess the contribution of the newer G8 summit-centred system, it is important to ask whether attention from the leaders of the most powerful countries actually makes a difference to the health of people around the world. This question has given rise to a broad debate.[4] Critics argue that the G8 has failed in terms of fundraising, and has been unable to raise the large amounts of money needed to combat human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and other diseases. In addition, the old UN system organizations have been unable to induce their own members to provide the necessary funds.[5,6] Other critics argue that the G8 has done too much of the wrong thing. They claim that its members remain attached to neo-liberal principles that are vital to improving health, and thus display "fatal indifference" to new patterns of disease.[7–10] Still different critics claim that the G8 fails to deliver on health because it is easily distracted by other issues, has a narrow audience and places a premium on short-term public relations success.[11–13]

Those who are supportive of the G8, however, argue that the G8 is emerging as the global-health governor. This is not out of choice, but as a consequence of the poor performance of the old multilateral organizations and the high technical and economic capacity of G8 members.[14,15] Other supporters view the G8 as a potential leader in the health field as a whole, and claim that the G8 is already forging a new path for global health governance in an era in which globalized markets threaten to overwhelm Member States.[16] Commentators have described the G8 as the emerging centre of 21st century global health governance.[17–22] This is because of the inclusive, multi-stakeholder model on which the G8 is now based, and stems from the identified need for task-oriented collaboration between the private and public sectors as the model for future global health governance.[17–22]

To advance this debate, we car-

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ried out an evidence-based assessment of G8 health governance and explored its impact on foreign policy and the domestic behaviour of G8 Member States. These include Canada, France, Germany, Italy, Japan, the Russian Federation, the United Kingdom, the United States and the European Union (EU).[2] Drawing on the concert equality model that uses six governance functions to explain institutional performance, we will first assess the G8's performance with respect to its health commitments. These six functions are: supporting the domestic management of policies and politics; deliberating on key issues; defining new directions and future commitments; taking collective decisions about specific commitments; delivering these decisions through members' compliance with their commitments; and developing global governance by creating new and directing existing international institutions. We examine whether G8 members comply with their collective commitments, and why. We explore whether G8 leaders, through their active use of compliance catalysts, plurilateral institutions and multilateral organizations, can work to ensure greater compliance with global health goals.

G8 global health governance

Since the onset of rapid globalization in 1996, the G8 has emerged as a more effective leader of global health governance than other existing institutions (see Table 1).[23–27] In relation to its first function of domestic political management, the Group of Seven (G7), then without the Russian Federation, initially took up health issues that concerned the Member States at that time, such as cancer. The G7's concerns subsequently gravitated towards diseases, such as malaria, that primarily affect countries outside of the G7. When the Russian Federation became a full member in 1998, the G8 began to focus on HIV/AIDS, which was becoming increasingly prevalent within that country. As hosts of the 2006 St Petersburg Summit, the Russian Federation's choice of infectious disease as one of three priority themes was driven by concern that the epicentre of HIV/AIDS was migrating from Africa to Eurasia, and it sought to address the issue of HIV/AIDS within its own borders. A poll taken on the summit's eve identified infectious disease as a key issue, voted for by 84% of Russian respondents and 86% of those in the G8, and giving the topic second priority after terrorism.[28]

The second function of the G8 is deliberation, in which outcomes are measured by the number of paragraphs devoted to health topics in summit declarations issued in the leaders' names. Health became a major agenda item in 1996 and 1997 under French and American leadership and continued to grow as an issue. At the 2006 summit a record 84 paragraphs were devoted to health. In relation to the third function of setting new normative directions, the G8 in 2002 began to place priority on health by dealing with the subject in the Chair's Summary document, which highlights the leaders' top priorities. At the St Petersburg Summit in 2006, the Chair's Summary devoted a record eight paragraphs to infectious disease. In reference to health, documents generated from the summit emphasized democratic principles and civil society participation.

Collective decision-making is the fourth function of G8 Member States, whereby future commitments are documented and published in the leaders' names. In relation to this function, the first inclusion of health issues occurred in 2002. During this time, under Canadian leadership, 25 commitments were made. The St Petersburg Summit in 2006 set a record high of 64 health commitments, double the number made by any previous summit. Increased commitment to mobilizing new money for global health began under French leadership in 2003. At the British-hosted Gleneagles Summit in 2005, a record of US$ 24 billion was committed to global health.

Compliance with these commitments, the fifth function of G8 Member States, involves the actual implementation of these collective decisions. In this respect, however, performances by G8 Member States have varied. On this issue the best systematic evidence comes from the G8 Research Group's annual assessment of members' compliance with critical commitments in the year following the summit. The role of the G8 Research Group is to assess the actions taken by member governments, including verbal reaffirmations, assigning personnel and resources, initiating new programmes and documenting whether the commitments result in their intended effect.[29] First-order compliance is measured on a scale from –100% to +100%. Minus 100% represents no action or a Member State acting against fulfilling the commitment; +100% represents complete compliance with it. Compliance with the critical health commitments made at the Summits hosted by Japan in 2000 and France in 2003 was very high, but it has been considerably lower in other years.

Finally, in relation to the sixth function of G8 members, to ensure the development of global governance, there has been steady action in relation to health since 2001. This function is measured by the number of G8-centred health institutions created at the ministerial and official level, during the Summit hosting year. Prior to 2001 results were poor, with only one or two institutions created each year and none created in 2005. Only in 2006 was this issue addressed at the ministerial level, with the first-ever meeting of G8 health ministers.

Thus with respect to its first four functions the G8 has increased its outputs relating health, with virtually all of its members contributing to this rise during their leadership. This pattern suggests that the G8 is indeed a concert of equals, driven to govern in health as elsewhere in accordance with the concert equality model of G8 governance.[26,30–32] This change has come about because of the increasingly equal vulnerability of citizens from each G8 Member State to a new generation of infectious diseases, including HIV/AIDS. Older organizations within the UN system, led by WHO, have proven increasingly ineffective in mobilizing their members' resources on the scale required and in meeting targets and timetables.[5,14,15] By contrast, the G8 Member States possess the globally predominant and specialized capabilities needed to combat these new diseases worldwide. Their core, common, G8-grounded principles of open democracy and social advance bring G8 leaders close to their newly democratic African partners, who are more comfortable with the multi-stakeholder approaches required to combat a new generation of diseases. From 2001 to 2005, seven of the same leaders came to an unprecedented five summits in a row, to meet the same four core democratic African partners in the G8 club. At these summits they discussed global health in the inclusive, interlinked and innovative way the world needs.

Table 1. **Overview of G8 health performance**

	Deliberative[a]	Directional[b]	Decisional: total commitment[c]	Decisional: money (US$)[c]	Delivering commitments[d]	Development of global governance[e]
1975	0	0	0	0	NA	0
1976	0	0	0	0	NA	0
1977	0	0	0	0	NA	0
1978	0	0	0	0	NA	0
1979	1	0	0	0	NA	0
1980	1	0	0	0	NA	0
1981	0	0	0	0	NA	0
1982	4	0	0	0	NA	0
1983	1	0	1	0	NA	0
1984	1	0	0	0	NA	0
1985	2	0	0	0	NA	0
1986	2	0	1	0	NA	0
1987	7	0	0	0	NA	1
1988	2	0	0	0	NA	0
1989	3	0	0	0	NA	0
1990	7	0	0	0	NA	0
1991	9	0	1	0	NA	0
1992	3	0	0	0	NA	1
1993	3	0	1	0	NA	0
1994	2	0	0	0	NA	0
1995	2	0	0	0	NA	0
1996	14	0	5	0	+43%[f]	0
1997	17	0	10	0	0.0%[f]	0
1998	6	0	5	0	+26%[f]	0
1999	11	0	4	0	+32%[f]	0
2000	30	0	17	0	**+84%**[f]	0
2001	15	0	5	1.3 billion	+38%[f]	1
2002	19	2	25	0	+17%[f]	1
2003	50	6	32	500 million	+80%[f]	**2**
2004	36	5	14	3.3 billion	+33%[f]	1
2005	22	1	14	**24 billion**	+24%[f]	0
2006	**84**	**8**	**64**	4.4 billion		1

NA, not available; US$, United States Dollars. Bold type indicates peak scores.

[a] Annual assessment of G8 leaders' references to health in annual documentation, including Chair's Summary. Each paragraph containing a mention of health is counted as 1.

[b] Annual assessment of G8 leaders' references to health in the communiqué chapeau, introduction or Chair's Summary. Each paragraph containing a mention of health is counted as 1.

[c] Annual assessment of G8 leaders' specific future-oriented commitments in the leaders' name. Each commitment is counted as 1.

[d] Annual assessment of member's compliance with critical commitments in the year after the Summit, measured on a scale from −100% to +100%.

[e] The number of G8-centred health institutions created at the official and ministerial level during the Summit hosting year.

[f] Data supplied by the University of Toronto G8 Research Group and Jenevieve Mannell.

Compliance with G8 health commitments

Of the six G8 global governance functions, compliance stands out as not corresponding to the G8's improved commitment to global health issues. From 1996 to 2005, compliance as the G8's fifth function scored on average only +35%. Although health compliance has scored positively every year, scores vary widely, with very high compliance noted in both 2000 and 2003.

Variations in compliance are also seen across Member States. From 1996 to 2005, the average scores in decreasing order were as follows: European Union (EU) +81%, United Kingdom +64%, Canada +63%, United States +57%, France +43%, Germany +34%, Japan +31%, Italy +22% and the Russian Federation +10% (see Table 2). This pattern is similar to that for compliance with commitments from other areas aside from health. These data suggest that highly organized institutions such as the EU may reinforce the G8's health compliance task rather than serving to rival or replace the G8.

With respect to health, compliance varies even more widely by component issue area. For example, from 1996 to 2005 the average scores were in decreasing order: severe acute respiratory syndrome (SARS) +78%, ageing +67%, biotechnology +66%, the Global Fund to fight AIDS, Tuberculosis and Malaria +56%, drugs and medicine +49%, HIV/AIDS +33%, polio +31%, training +29% and development 0%. This pattern suggests that the G8 performs better when the health issue in question most directly affects citizens in G8 countries,

Table 2. **G8 health compliance by country and health issue**

Health commitments by year[a]	Average score	Canada	France	Germany	Italy	Japan	Russian Federation	United Kingdom	United States	European Union
Polio	**+31%**	**+60%**	**−20%**	**+60%**	**−20%**	**0%**	**+20%**	**+60%**	**+60%**	**+67%**
2002	0.00	0	0	0	0	0	0	0	0	NA
2003	+1.00	+1	+1	+1	+1	+1	+1	+1	+1	NA
2004	+0.44	+1	−1	+1	−1	0	+1	+1	+1	+1
2004	0.00	0	0	0	0	0	0	0	0	0
2005	+0.11	+1	−1	+1	−1	−1	−1	+1	+1	+1
HIV/AIDS	**+33%**	**+80%**	**+100%**	**−20%**	**00%**	**−20%**	**−75%**	**+80%**	**+80%**	**+75%**
1998	+0.33	+1	+1	0	−1	0	−1	+1	+1	+1
1998	+0.11	+1	+1	−1	−1	−1	−1	+1	+1	+1
1999	+0.63	+1	+1	−1	+1	+1	0	+1	+1	NA
2002	0.00	0	NA	0	NA	0	NA	0	0	0
2004	+0.56	+1	+1	+1	+1	−1	−1	+1	+1	+1
Drugs/medicines	**+49%**	**+75%**	**+25%**	**+50%**	**+33%**	**+75%**	**+50%**	**+75%**	**+25%**	**+50%**
1996	+0.43	0	0	+1	NA	+1	NA	+1	0	NA
2000	+1.00	+1	+1	+1	+1	+1	+1	+1	+1	+1
2002	+0.38	+1	0	0	0	+1	0	+1	0	NA
2003	+0.13	+1	0	0	0	0	NA	0	0	0
Diseases: HIV, polio, malaria, tuberculosis	**+65%**	**+75%**	**+67%**	**+67%**	**+67%**	**+75%**	**00%**	**+67%**	**+50%**	**+100%**
1999	0.00	0	0	0	0	0	0	0	0	NA
2000	+0.60	+1	NA	NA	NA	+1	0	NA	0	+1
2000	+1.00	+1	+1	+1	+1	+1	NA	+1	+1	+1
2003	+1.00	+1	+1	+1	+1	+1	NA	+1	+1	NA
The Global Fund	**+56%**	**+75%**	**+50%**	**+25%**	**+50%**	**+50%**	**+75%**	**+50%**	**+50%**	**+100%**
2001	+0.75	+1	+1	+1	+1	0	+1	+1	0	NA
2002	+0.25	+1	0	0	+1	0	0	0	0	NA
2003	+0.89	+1	+1	0	+1	+1	+1	+1	+1	+1
2005	+0.33	0	0	0	−1	+1	+1	0	+1	+1
Development	**0%**	**−50%**	**−50%**	**+50%**	**−50%**	**0%**	**0%**	**+50%**	**+50%**	**NA**
1997	0.00	−1	−1	+1	−1	0	NA	+1	+1	NA
2001	0.00	0	0	0	0	0	0	0	0	NA
Biotechnology	**+66%**	**+100%**	**+100%**	**+50%**	**+50%**	**+100%**	**−100%**	**+100%**	**+50%**	**NA**
2000	+0.75	+1	+1	+1	+1	+1	−1	+1	+1	NA
2002	+0.57	+1	+1	0	0	+1	NA	+1	0	NA
Ageing	**+67%**	**+100%**	**+100%**	**+50%**	**+100%**	**+100%**	**+100%**	**+100%**	**+100%**	**+100%**
1998	+0.33	0	NA	0	NA	NA	NA	NA	+1	NA
2003	+1.00	+1	+1	+1	+1	+1	+1	+1	+1	+1
Training	**+29%**	**0%**	**+100%**	**0%**	**NA**	**+100%**	**NA**	**−100%**	**0%**	**+100%**
2005	+0.29	0	+1	0	NA	+1	NA	−1	0	+1
SARS	**+78%**	**+100%**	**+100%**	**0%**	**+100%**	**+100%**	**0%**	**+100%**	**+100%**	**+100%**
2003	+0.78	+1	+1	0	+1	+1	0	+1	+1	+1
Average scores	**35%**	**63%**	**43%**	**34%**	**22%**	**31%**	**10%**	**64%**	**57%**	**81%**

AIDS, acquired immunodeficiency syndrome; the Global Fund, the Global Fund to fight AIDS, Tuberculosis and Malaria; NA, not available; SARS, severe acute respiratory syndrome.

[a] For which G8 Research Group compliance data exists.

or involves instruments directly controlled by the G8 Member States. The G8 performs better within a biomedical model aimed at responding to acute outbreaks of diseases such as SARS, not at proactively addressing health's socioeconomic determinants and underdevelopment's root causes. This finding supports concerns that the G8 fails to adequately address a new generation of diseases because of its neo-liberal approach to economic and social policy.[7,8]

Compliance: explaining variations

What explains these patterns of compliance in relation to health? Although the concert equality model explains G8 performance on the other five functions of G8 governance, variation in performance on compliance is difficult to explain.[3,30,33] Recent research exploring G8 finance and development commitments suggests that compliance is linked to three factors:

- the conscious action of the G8 leaders as active agents at summits,
- the reinforcing action of the G8 ministerial institution, and
- the vulnerabilities and relative capabilities that constitute the structure of the international system.[48]

Is the same true in the field of health? Health is a much newer focus of the G8, and at present no G8 ministerial-level institution deals exclusively with health issues.

As active agents, G8 leaders at times consciously embed within their commitments expressions of their political will. Particular catalysts provide specific guidance about how to deliver their commitments. A recent analysis of compliance with 46 of the G8's finance and development commitments from 1996 to 2005 found that two catalysts improved compliance. These were priority placement, whereby reference is made to health in the communiqué chapeau, introduction, preamble or Chair's Summary, and timetable, where a specific target date or year is set. However, no improvements were seen from the other catalysts, which included:

- targets (specific, numerical, measurable goals);
- remit mandates (requirements to report back at the next summit);
- money mobilized (new money promised at the summit);
- specified agents (national or intergovernmental groups, institutions or individuals nominated to take charge of the commitment);
- G8 body (a named G8-centred or G8-created institution, its ministers, or members who take charge of the commitment);
- international institutions (whose named ministers or members take charge of the commitment).[25]

To explore the impact of these compliance catalysts in the field of health, some refinements were made. The timetable catalyst was divided into one-year variants and multiyear variants. International institutions were divided into WHO, the most functionally relevant multilateral organization, and "other". The commitment was coded as WHO when it contained a specific reference to this organization. All referenced multilateral institutional initiatives not exclusively directed by WHO, including references to the UN, the Joint UN Programme on HIV/AIDS (UNAIDS), the Codex Alimentarius Commission, the Global Polio Eradication Initiative and the Stop TB Partnership, were coded as other because they are partly directed by other organizations. The category "past promise", a reaffirmation of a commitment made in a previous year, was added to capture the important impact of iteration and continuity.[49]

Between 1996 and 2006 a health commitment contained up to four such catalysts and as few as none (see Table 3; available at http://www.who.int/bulletin). The most frequently employed catalysts across the 30 measured health commitments were, in decreasing order: priority placement (12 commitments), specified agent (10), other international institution (8), money mobilized (7), past promise (7), multiyear timetable (6), one-year timetable (4) and G8 body (4).

WHO was explicitly invoked in only two commitments: one in 2000 on HIV/AIDS, malaria and tuberculosis, for which the compliance score was +100%, and one in 2005 on polio, for which the compliance score was +11%. From 2003 onwards, priority placement and money mobilized have been the catalysts of choice.

The effect of the catalyst variables on commitment compliance was formally tested in a multivariate ordinary least squares (OLS) model.[52] In this model, which uses a subset of catalyst variables deemed to best balance the trade-off between predictive power and parsimony, two catalysts had highly significant positive effects on compliance. The presence of a specific timetable of one year or less tended to increase compliance with that commitment by an average of +0.65 compliance points, over and above the baseline value of average compliance with commitments without such a timetable (p-value=0.03; t-value=2.219). Similarly, delegating some responsibility for implementation to WHO tended to improve compliance with that commitment by +0.55 compliance points, in comparison to compliance with commitments not delegated to WHO (p-value=0.06; t-value=1.93). Although significant only at the 94% confidence interval level, the estimate is considered to be admissible given the small sample size.[53]

To identify more specifically why compliance differs from the overall level of compliance across all commitments in a given year, we calculated a mean-adjusted compliance variable from each individual commitment compliance score. In this analysis the only significant variables that emerged were international institution and "other". However, by delegating some responsibility for implementation to an international organization other than WHO, compliance tended to reduce by 5.9 compliance points relative to the baseline average compliance with commitments where this catalyst variable was absent (p-value=0.07; t-value=1.83).

A second potential cause of compliance is the conscious collective action of the ministers involved in G8 governance, who may autonomously seek to support their leaders even when solicited. In the field of finance and development, compliance increases when the G8 finance ministers act supportively.[25,54] Specifically, the G7/G8 finance ministers are coded as supportive of the health agenda if the ministers mention the issue-area of the commitment in their ministerial communiqué; for example, active ageing, polio eradication and supporting the Global Fund.

The G7/G8 finance ministers have been active on the issue of health almost continuously since 1998, and were particularly engaged in 2000 and 2003. In 2000, three of the six G7/8 finance ministers meeting dealt with health issues, and in 2003 this increased to

three of the four ministries. In addition, both 2000 and 2003 had a higher than average number of compliance catalysts embedded by the leaders in their health commitments. In addition, 2000 and 2003 are the same years in which there was a peak of health compliance. Yet regression analysis highlights that when the G8 finance ministers addressed the same issue as that contained in their leaders' health commitments, it had no effect on compliance before, during or after the summit year. In conclusion, G8 leaders must look outside their current G8 institutional system if they are to improve compliance.

The efforts of G8 leaders and finance ministers to improve compliance with health commitments will likely be driven by changes in the structure of the international system. This is because the relevant vulnerabilities and capabilities among G8 members will change over time. In the field of finance and development, a combination of increasingly equal vulnerability and capability among the G8 members has in the past inspired finance ministers to remember and repeat such commitments, but this did not directly increase compliance.[25] However, with respect to health no indirect or direct impact has been identified. There have been no impacts noted on the demand side, even when G8 Member States have shown increased vulnerability to pandemics such as HIV/AIDS. Nor have there been impacts on the supply side, despite the fact that the ability of G8 members to respond to health issues has become more internally equal and globally predominant.

Conclusion

Our analysis indicates that G8 leaders can improve compliance with the health commitments that they make at annual summits. We conclude that health ministers and other health-policy stakeholders can do three things to ensure health commitments are addressed during the first year. First, they can encourage G8 leaders to make health commitments at the summit and to set a one-year timetable for action. This timetable should correspond with the period within which compliance is measured, and the interval between this and the next summit. Second, they should advise G8 leaders to seek the support of WHO, especially on issues that relate to HIV/AIDS, malaria and tuberculosis.[4] Third, they should work to create a G8 health ministers institution by building on the success of the first meeting of G8 health ministers that took place in 2006.

Both the UN and the G8 systems can assist the powerful countries assembled in the G8 to comply with the rising number of health commitments that they make. In both cases it will be institutions that are fully focused on health, rather than those with more diffuse responsibilities, that can be counted on to ensure improved compliance. ■

Competing interests: None declared.

Résumé

Comment les dirigeants du G8 ont honoré leurs engagements dans le domaine sanitaire de 1996 à 2006

Les responsables de l'élaboration des politiques internationales en matière de santé disposent désormais d'un éventail d'instruments institutionnels pour les aider à atteindre leurs objectifs sanitaires mondiaux et nationaux. Il s'agit aussi bien d'organisations multilatérales bien établies du système des Nations Unies, que d'institutions plus récentes et à composition plus restreinte, mises sur pied dans le cadre du G8. Pour déployer au mieux les ressources limitées dont on dispose, il importe d'examiner systématiquement la contribution apportée par le G8 à la gouvernance sanitaire mondiale. Cette évaluation examine les contributions des organisations multilatérales comme l'Organisation mondiale de la Santé et détermine si les Etats Membres respectent leurs engagements. L'étude a cherché à vérifier dans quelle mesure la gouvernance sanitaire du G8 aide les gouvernements des pays membres à gérer les politiques au plan interne, à définir les principales orientations normatives, à développer et à respecter des engagements pris à titre collectif et à mettre sur pied de nouvelles institutions rattachées au G8. L'étude a permis de constater que les résultats obtenus par le G8 s'étaient sensiblement améliorés au cours des dix dernières années. Les résultats sont également satisfaisants au niveau des différents Etats Membres du G8, chacun se révélant en mesure de lutter contre les maladies. Le respect des engagements dans le domaine sanitaire varie cependant d'un Etat à l'autre, et des améliorations peuvent encore être apportées. Ainsi, les dirigeants du G8 devraient mieux définir leurs engagements en matière de santé et se fixer un délai d'une année pour les honorer. En outre, les Etats Membres devraient demander l'appui de l'OMS et créer un organisme regroupant les ministres de la santé des pays du G8.

Resumen

Análisis del cumplimiento de los compromisos de los líderes del G8 en materia de salud (1996–2006)

Los planificadores de las políticas internacionales de salud disponen en la actualidad de diferentes instrumentos institucionales para alcanzar sus objetivos sanitarios mundiales y nacionales. Esos instrumentos van desde las organizaciones multilaterales oficiales de las Naciones Unidas hasta instituciones más recientes y restringidas del Grupo de los Ocho (G8). Para decidir la mejor forma de emplear recursos escasos, debemos examinar de forma sistemática las contribuciones del G8 a la gobernanza de la salud mundial. En este estudio exploramos las contribuciones hechas por las instituciones multilaterales, tales como la Organización Mundial de la Salud (OMS) e investigamos si los Estados Miembros cumplen sus compromisos. Hemos analizado si la gobernanza sanitaria del G8 ayuda a sus gobiernos miembros a gestionar la política y las políticas nacionales, a definir las principales direcciones normativas, a desarrollar y cumplir los compromisos colectivos y a crear nuevas instituciones centradas en el G8. Hemos verificado que el desempeño del G8 ha mejorado considerablemente en el último decenio. Los Estados Miembros del G8 funcionan igualmente bien, y todos ellos son capaces de luchar contra las enfermedades. El cumplimiento de sus compromisos sanitarios fue variable entre los Estados Miembros del G8, y este aspecto es mejorable. Los líderes del G8 deben definir mejor sus compromisos sanitarios y fijar plazos anuales para su cumplimiento. Además, los Estados Miembros deben buscar el apoyo de la OMS y crear una institución formada por los ministros de salud del G8).

ملخص

تمكين قادة البلدان الثمانية الكبرى من العطاء: تحليل للامتثال وللالتزامات الصحية، 1996 – 2006

إن لدى أصحاب القرار السياسي في الصحة الدولية مجموعة من الأدوات المؤسساتية تمكّنهم من تحقيق المرامي الصحية الوطنية والعالمية. وتـتراوح هذه الأدوات من المنظمات الرسمية المتعدِّدة الأطراف للأمم المتحدة إلى المؤسسات المحدودة العضوية لمجموعة البلدان الثمانية الكبرى، وللوصول إلى قرار حول أفضل مكانٍ لتوظيف الموارد الشحيحة كان من الواجب علينا أن نقوم بدراسة منهجية للمساهمات التي قدَّمتها الدول الثمانية الكبرى للجهات القائمة على حَوْكَمة الصحة في العالم. ويستقصي هذا التقيـيم المساهمات التي قدَّمتها مؤسسات متعدِّدة الأطراف مثل منظمة الصحة العالمية، وفيما إذا كانت الدول الأعضاء قد التزمت بأداء ما عليها من التزامات. كما قيَّمنا ما إذا كانت الجهات القائمة على الحكومة الصحية في البلدان الثمانية الكبرى، قد ساعدت الحكومات في دولها الأعضاء في إدارة السياسات الوطنية وفي أدائها السياسي، وفي تعريف الاتجاهات المعيارية السائدة، وفي إعداد الالتزامات الجماعية والامتثال لها، وفي إعداد مؤسسات جديدة تـتركز في البلدان الثمانية الكبرى. وقد وجدنا أن أداء البلدان الثمانية الكبرى قد تحسَّن تحسُّناً واضحاً خلال العقد المنصرم، وأن أداء البلدان الأعضاء في مجموعة البلدان الثمانية الكبرى متساوٍ في جودته، وأن كلاً منها يستطيع مكافحة المرض. ويتفاوت الامتثال بين الدول الثمانية الكبرى بقدر ما لدى كل منها من التزامات صحية، مع وجود مجال للتحسُّن. وعلى قادة البلدان الثمانية الكبرى أن يحدِّدوا التزاماتهم بشكل أفضل، وأن يحدِّدوا الزمن الأقصى للعطاء خلال عامٍ واحد؛ وبالإضافة إلى ذلك ينبغي على الدول الأعضاء أن تلتمس المعونة من منظمة الصحة العالمية في إعداد مؤسسة لوزراء الصحة في الدول الثمانية الكبرى.

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Table 3. **G8 health commitments with compliance catalysts**

Commitment	Individual commitment score	Overall summit score	Overall health summit score	Number of catalysts	Priority placement[a]	Timetable (1 year)[b]	Timetable (multiyear)[c]	Remit mandate[d]	Money mobilized[e]	Specified agents[f]	International institution: WHO[g]	International institution: other[h]	G8 body[i]	Past promise[j]
1996 drugs	+0.43	+36.0	+0.43	1	0	0	0	0	0	0	0	1	0	0
1997 development	0.00	+12.8	0.00	1	0	0	0	0	0	1	0	0	0	0
1998 HIV	+0.33	+0.32	+0.26	2	0	0	0	0	0	0	0	1	0	1
1998 HIV	+0.11	+0.32	+0.26	1	0	0	0	0	0	0	0	0	1	0
1998 ageing	+0.33	+0.32	+0.26	0	0	0	0	0	0	0	0	0	0	0
1999 HIV	+0.63	+0.44	+0.32	1	0	0	0	0	0	0	0	0	0	1
1999 HIV, polio, tuberculosis	0.00	+0.44	+0.32	1	0	0	0	0	0	0	0	0	0	1
2000 HIV, malaria, tuberculosis	+0.60	+0.81	+0.84	0	0	0	0	0	0	0	0	0	0	0
2000 HIV, malaria, tuberculosis	+1.00	+0.81	+0.84	3	0	0	1	0	0	1	1	1	0	0
2000 drugs	+1.00	+0.81	+0.84	4	0	1	0	0	0	1	0	1	0	1
2000 biotechnology	+0.75	+0.81	+0.84	2	0	0	1	0	0	0	0	1	0	0
2001 Global Fund	+0.75	+0.46	+0.38	4	0	1	0	0	1	0	0	1	0	1
2001 development	0.00	+0.46	+0.38	1	0	0	0	0	0	1	0	0	0	0
2002 polio	0.00	+0.36	+0.17	2	1	0	1	0	1	0	0	0	0	0
2002 HIV	0.00	+0.36	+0.17	0	0	0	0	0	0	0	0	0	0	0
2002 medicines	+0.38	+0.36	+0.17	2	0	0	0	0	0	1	0	0	0	1
2002 Global Fund	+0.25	+0.36	+0.17	3	1	0	0	0	0	0	0	0	1	1
2002 biotechnology	+0.57	+0.36	+0.17	0	0	0	0	0	0	0	0	0	0	0
2003 ageing	+1.00	+0.51	+0.80	1	1	0	0	0	0	0	0	0	0	0
2003 Global Fund	+0.89	+0.51	+0.80	4	1	1	0	0	1	1	0	0	1	0
2003 polio	+1.00	+0.51	+0.80	2	1	0	1	0	1	0	0	0	0	0
2003 SARS	+0.78	+0.51	+0.80	1	1	0	0	0	0	0	0	0	0	0
2003 medicines	+0.13	+0.51	+0.80	2	1	0	0	0	0	1	0	0	0	0
2003 HIV, malaria, tuberculosis	+1.00	+0.51	+0.80	1	1	0	0	0	0	0	0	0	0	0
2004 HIV	+0.56	+0.55	+0.33	1	1	0	0	0	0	0	0	0	0	0

(Table 3, cont.)

Commitment	Individual commitment score	Overall summit score	Overall health summit score	Number of catalysts	Priority placement[a]	Timetable (1 year)[b]	Timetable (multiyear)[c]	Remit mandate[d]	Money mobilized[e]	Specified agents[f]	International institution: WHO[g]	International institution: other[h]	G8 body[i]	Past promise[j]
2004 polio	+0.44	+0.55	+0.33	3	1	1	0	0	1	1	0	0	0	0
2004 polio	0.00	+0.55	+0.33	2	1	0	1	0	0	0	0	0	0	0
2005 training	+0.29	+0.65	+0.24	1	0	0	0	0	0	1	0	0	0	0
2005 Global Fund	+0.33	+0.65	+0.24	4	1	0	0	0	1	1	0	1	1	0
2005 polio	+0.11	+0.65	+0.24	3	0	0	1	0	1	1	1	1	0	0
Total scores	**NA**	**NA**	**NA**	**53**	**12/30**	**4/30**	**6/30**	**0/30**	**7/30**	**10/30**	**2/30**	**8/30**	**4/30**	**7/30**

Global Fund, the Global Fund to fight AIDS, Tuberculosis and Malaria; HIV, human immunodeficiency virus; NA, not available; SARS, severe acute respiratory syndrome.

[a] The presence (1) or absence (0) of the issue in the communiqué chapeau, introduction, preamble or Chair's Summary.
[b] The presence (1) or absence (0) of a one-year timetable in the text of the commitment.
[c] The presence (1) or absence (0) of a more than one-year timetable in the text of the commitment.
[d] The presence (1) or absence (0) of a requirement to report back at the next Summit in the text of the commitment.
[e] The presence (1) or absence (0) of new money promised in the text of the commitment.
[f] The presence (1) or absence (0) of a national or intergovernmental group, institution or individual to take charge of the commitment in the text of the commitment.
[g] The presence (1) or absence (0) of a reference to WHO or its initiatives in the text of the commitment. Although this analysis of compliance with 30 health commitments contains only two cases where the WHO compliance catalysts is used, a parallel analysis of 35 cases of compliance with G8 health commitments from 1996 to 2006 confirms these results.[50, 51]
[h] The presence (1) or absence (0) of a reference to any multilateral institutions or initiatives not exclusively directed by WHO in the text of the commitment.
[i] The presence (1) or absence (0) of a reference to a G8-centred or G8-created institution, its ministers or members named to take charge of the commitment in the text of the commitment.
[j] The presence (1) or absence (0) of the reaffirmation of a commitment made in a previous year, within the text of the commitment.